

Apr 12 12 05:23p elaine keating

347-789-5376

p.1

Richard Keating

466 rockaway parkway Apt 5D

To whom it may concern

I Richard Keating employee for auto-chlor branch 6:30 system of Apr 12 2012 is handing in my resignation. Thank you for the opportunity for working with you for the past ten years, if any question please contact me at (347)4763306.

Yours truly

Richard Keating

A handwritten signature in black ink, appearing to read 'R. Keating', followed by a large, sweeping flourish that extends to the right.

EMPLOYEE INFORMATION SHEET

OCT 05 2001
~~AUG 23 2001~~

#1381

Richard Keating

NAME

510 E 20th St Apt. 8H

HOME ADDRESS

NYC, NY, 10009

CITY/STATE/ZIP

212 477-1052

HOME TELEPHONE NUMBER

718 529 0801

EMERGENCY CONTACT/PHONE #

PHYSICIAN/PHONE NUMBER

SEND TO CORPORATE OFFICE:

W-4 FEDERAL/STATE

EMPLOYMENT AGREEMENT

INSURANCE ENROLLMENT FORM:

A. WANTS COVERAGE

B. DECLINES COVERAGE

LONG TERM DISABILITY FORM

1-9 IMMIGRATION FORM

EMPLOYEE INFO SHEET

SIGN PAGE FROM EMP MANUAL

SAVINGS FORM

DIRECT DEPOSIT AUTH. FORM

BENEFIT ENHANCER FORM

PROPERTY INFORMATION:

GAS CREDIT CARD #

PHONE CREDIT CD #

BUILDING KEY

VEHICLE KEY

SOCIAL SECURITY NUMBER

03 104164

DATE OF BIRTH

299423542 NY

DRIVER'S LICENSE #/STATE

12/89 Hired from Basic Company

DATE OF HIRE Hired by Auto-Chlor System

8/13/01 9-24-01 1625,

RATE OF PAY/FULL TIME/PART TIME

630 Route

BRANCH # /POSITION

EMPLOYEE MGR
INITIAL INITIALSENT TO
CORPORATE

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*ISSUED

**RETURNED

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |



Commercial Dishwashing & Laundry Service

STATEMENT OF AWARENESS

THIS STATEMENT OF AWARENESS SHOULD BE READ CAREFULLY BEFORE SIGNING

I have read and fully understand the rules and policies described in this handbook and I understand that they may be changed by the Company at any time without prior notice to me. I understand that any changes in the rules and policies will be in writing. I understand that any violation or deviation from the Company's rules and policies by me is a serious matter and may result in disciplinary action, including discharge. I agree to conform to the rules and policies of the Company.

I understand that, although certain of the Company's rules and policies specifically provide for discharge in the event of violation, the circumstances under which I may be discharged are not limited to failure to comply with those or any other rules or policies contained in this handbook. I understand that my employment by the Company can be terminated with or without cause and with or without notice, at any time, at my option or at the option of the Company. I understand that no manager or representative of the Company other than its Chief Executive officer has any authority to enter into any agreement with me for employment not covered in the provisions of this Statement of Awareness. I understand that no manager or representative of the Company other than the Chief Executive Officer (or such persons as might be designed) has any authority to alter or amend the Company's rules and policies. I understand that no rule or policy can be changed orally and that all changes, if any, must be in writing.

Kimberly Keating
(Name)

Aug 13 2001
(Date)

[Signature]
(Signature)

630
(Location and Department)



Corrective Action Form

| | |
|---------------------------------------|---------------------------------|
| Employee Name: <u>Richard Keating</u> | Date of Warning: <u>7.27.11</u> |
| Branch <u>630</u> | |

| | | |
|---|-----------------------|------------------------|
| Type of Violation (circle) Attendance Safety <u>(Dishonesty/Theft)</u> Carelessness Tardiness | | |
| <u>(Insubordination)</u> Work Quality Drug/Alcohol | | |
| Violation Date: <u>6/2/11</u> <u>6/24/11</u> <u>7/28/11</u> | Violation Time: _____ | Place: <u>MR. Tong</u> |

Company Statement:

See Attachment

Employee Statement:

☐ I agree with Statement
☐ I disagree with Statement for the following reasons:

Employee Signature: X
 Date: 7.27.11

Richie will be suspended for 3 days w/o pay.

Warning Decision

Approved by: S. Villanueva Title: Br Mgr Date: 7.27.11

Previous Warnings:

Date: 6/24/11
 Y/W _____

Date: 6/28/11
 V/W _____

I have read this "warning decision" and understand it.

Employee Signature Richard Keating Date 7/27/11

Supervisor's Signature S. Villanueva Date 7.27.11

Follow-Up Date: _____

7-27-11

Richie was given a service call to replace motor inlet line on an A4 at Mr Tong's in Queens on 6/2/11. He submitted a service report saying that he replaced the pipe. The next route day 6/24/11 the driver called me saying that the customer is very upset that he has had the same problem for another month. When I asked Richie what happened and why didn't he notify me that he did not replace the pipe, he said it wasn't leaking. I sent Richie back to the customer to replace the pipe on 6/24/11 and made it very clear that it was unacceptable that the job was not done and even more disturbing that he didn't communicate with me. On 7/26/11 the Route driver stated to me that the customer refused to pay his invoice and was very upset at the fact that we still had not fixed the leak on his machine. I disagreed with the driver saying that the pipe was replaced last month and that he and the customer must be mistaken. The driver assured me it was not replaced and that he had patched it temporarily. When Mike and I questioned Richie he stated that the job could not be done without plumbing work. He said several times that there were several drain pipes in the way that needed to be cut out to complete the repair. When we asked why he didn't communicate this information last month he had no answer. Mike and I went to the account and replaced the pipe in 12 min without any plumbing work. The drain pipe that was in the way had a rubber T coupling that was easily removed. Richie did not complete a given task and falsified company a document saying he did complete the task. He also failed to notify the company that the job was not done and that he felt it need plumbing work until he was approached. Richie put the relationship with the customer and the company at risk which is unacceptable.

Final written warning



Corrective Action Form

| | |
|---------------------------------------|---------------------------------|
| Employee Name: <u>Richard Keating</u> | Date of Warning: <u>6/30/11</u> |
| Branch <u>630</u> | |

| | | |
|---|----------------------------------|----------------------------|
| Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness Insubordination Work Quality Drug/Alcohol | | |
| Violation Date: <u>6/28/11</u> | Violation Time: <u>afternoon</u> | Place: <u>in the Field</u> |

Company Statement: I called Richie upon 6/28/11 & he told me he was in front of Best pizza to service the account. The next day 6/29/11 the customer calls up upset saying no one has been @ his rest. to fix his dispenser. When I asked Richie he said he left the place w/o going in.

Employee Statement:
☐ I agree with Statement
☐ I disagree with Statement for the following reasons:

Employee Signature: [Signature]
 Date: _____

Warning Decision
 I don't know why Richie took it upon himself not to complete the service call, But he continues to withhold information from management and make management decisions. If this continues Richie will be terminated.

Approved by: Samuel Villanueva Title: BR Mgr Date: 6-29-11

Previous Warnings:

Date: _____
 V/W _____

Date: _____
 V/W _____

I have read this "warning decision" and understand it.

Employee Signature [Signature] Date 6/30/11

Supervisor's Signature _____

Date _____

Follow-Up Date: _____



Corrective Action Form

Employee Name
Richard Keating
Branch 630

Date of Warning: 10-4-10

Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness
Insubordination Work Quality Drug/Alcohol

Violation Date: 10-1-10 **Violation Time:** _____ **Place:** _____

Company Statement:
See attachment

Employee Statement:
☐ I agree with Statement
☐ I disagree with Statement for the following reasons:

Employee Signature: _____
Date: _____

Warning Decision

This is a Final Written warning. Rich's ability to complete a task effectively is poor. His disorganization and carelessness is unacceptable. Rich must complete the calls effectively or ask for help. Rich must keep his new tools, van and uniforms organized and clean as best as possible.

Approved by: S.Villanueva

Title: Branch MGR

Date: 10-4-10

Previous Warnings:

Date: 9-10-10
V/W _____

Date: _____
V/W _____

I have read this "warning decision" and understand it.

Employee Signature

Date

Supervisor's Signature

Date

Follow-Up Date: _____

10-4-10

Company Statement:

Rich was sent to Sandoony to repair a laundry dispenser in which chemicals were not pumping. He reported that the job was complete. Several days later the sales person called me saying that chemicals are still not dispensing. I went and found 3 out of the 4 dispensers were not dispensing chemicals. 2 of them had obvious leaks that had been going on for quiet some time. Richie has been to La Gamin several times now for a leak. They called again today saying it is still leaking. Rich was sent to 12th st bar to repair any and all issues they had with their machine. After the 1st visit he reported they needed some parts. He returned with the parts and when asked by me said the job was complete and working properly. The customer called twice over the weekend upset saying the machine is still not working. Rich was given tools, which he told me he never received. He was given new uniforms, which were found by me, already dirty thrown in the back of the van.

Charles removed all the DW & chemical parts from the Ford van at that time he noticed several tools and parts that Rich said we did not have. Charles found approx. over \$2500 in parts buried in dirt and grease inside of Rich's van. Charles also found his pay stubs and passport in the van.



Verbal
Written Warning
not a write up

Corrective Action Form

Employee Name

Richard Keating

Branch_630

Date of Warning:__

9-10-10

Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness
Insubordination Work Quality Drug/Alcohol

Violation Date:__ 9-9-10__ **Violation Time:**__ **Place:**__

Company Statement:

Richard was asked on several different occasions to perform several tasks in the course of a day. On multiple occasions Richard has not completed these task in the time allotted. On 9-9-10, I asked Richie to rebuild a UC34, re-install a motor to a CMA180, remove motors from the floor & to move several machines from the back of the warehouse. Only the CMA motor was done. Richie's productivity is very little.

Employee Statement:

☐ I agree with Statement
☐ I disagree with Statement for the following reasons:

Employee Signature: 

Date:__ 9/10/10__

Warning Decision

This is a only a verbal warning. Richard's productivity must improve. Richard must begin to complete the daily tasks assigned to him in a timely manner. I should not have to ask several times to complete the same task.

Approved by: S.Villanueva

Title: Branch MGR

Date: 9-10-10

Previous Warnings:

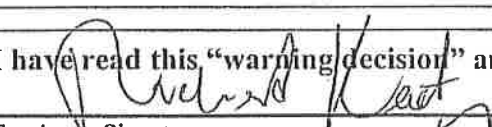
Date: _____

V/W _____

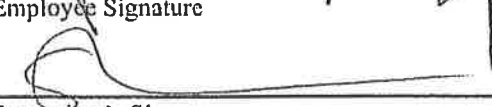
Date: _____

V/W _____

I have read this "warning decision" and understand it.

Employee Signature 

Date

Supervisor's Signature 

Date

9.10.10

Follow-Up Date:_____



Corrective Action Form

Employee Name Richard Keating Date of Warning: 1.29.10

Branch: B30

Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness
Insubordination Work Quality Drug/Alcohol

Violation Date: 1.28.10 Violation Time: 9⁰⁰ Am Place: BR B30

Company Statement: Richard
 Called me on 1/28/10 asking
 for a day off I did not approve it
 because of the work load & recent
 absences. Richard continued to
 Ask me to do him a favor
 but I explained I could not.
 Richard did not report to
 work.

Employee Statement:

I agree with Statement

I disagree with Statement for the
 following reasons:

Employee Signature: Richard Keating

Date: 1/29/10

Warning Decision

Richard Did not report to work, he has had several
 absences this month & will be suspended

Approved by:

S. Villanueva

Title:

BR mgr

Date:

1.29.10

Previous Warnings:

Date: _____
 V/W _____

Date: _____
 V/W _____

I have read this "warning decision" and understand it.

Employee Signature _____

Date _____

Supervisor's Signature _____

Date _____

Follow-Up Date: _____



Corrective Action Form

| | |
|--|-------------------------------------|
| Employee Name Richard Keating Branch <u>630</u> | Date of Warning: 11-24-09 |
|--|-------------------------------------|

| | | |
|---|------------------------------------|-----------------------------|
| Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness Insubordination Work Quality Drug/Alcohol | | |
| Violation Date: <u>11-18-09</u> | Violation Time: <u>5 pm</u> | Place: <u>Branch</u> |

| |
|---|
| Company Statement: Richard has been warned & written up before for not communicating when he is assigned a job and it is not completed for any reason. On wed. 11-18-09, I asked Richie to pick up money or shut off Tutores after 4pm. He called me to say that they were closed at that time, so I asked him to return to the shop & post the R+R on the board so the tech oncall can go later that night. When he returned that night Richie did not post the R+R nor did he call me to inform me that the tech on call had left the shop without his copy of the R+R. |
|---|

| |
|--|
| Employee Statement: <input type="checkbox"/> I agree with Statement <input type="checkbox"/> I disagree with Statement for the following reasons: |
| |
| Employee Signature: _____ Date: _____ |

| | | |
|---|-------------------|----------------|
| Warning Decision | | |
| This is a Final Written Warning, Richard must understand the importance of communicating with his supervisor in order to provide the service needed to our customers. If this continues Richard will be terminated. | | |
| Approved by: S.Villanueva | Title: Branch MGR | Date: 11-24-09 |

| |
|---|
| Previous Warnings: Date: <u>9-17-07</u> V/W _____ Date: <u>7-18-08</u> V/W _____ |
|---|

| | |
|--|-------------------------|
| I have read this "warning decision" and understand it. | |
| Employee Signature | <u>11/24/09</u> Date |
| Supervisor's Signature | <u>11.24.09</u> Date |

| |
|------------------------------|
| Follow-Up Date: _____ |
|------------------------------|



Corrective Action Form

| | |
|--|----------------------------------|
| Employee Name <u>Richard Keating</u> Branch <u>630</u> | Date of Warning: <u>12/16/08</u> |
|--|----------------------------------|

| | |
|--|---|
| Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness Insubordination <u>Work Quality</u> Drug/Alcohol | |
| Violation Date: <u>12/15/08</u> | Violation Time: <u>5³⁰ pm</u> Place: _____ |

Company Statement: Richard continues to want to disregard or alter directions given to him by BR Mgr. He continues to contribute to the disorganization of the shop by not placing things where they belong. Start time is 9 AM unless specified. you must punch in & check in for daily task after punch in.

Employee Statement:
 I agree with Statement
 I disagree with Statement for the following reasons:

Employee Signature: [Signature]
 Date: _____

Warning Decision
 There must be immediate improvement w/ all points mentioned above or it will lead to suspension or termination.

| | | |
|--|-------------------------|--------------------------|
| Approved by: <u>Samuel Villanueva</u> | Title: <u>BR MGR</u> | Date: <u>12/16/08</u> |
|--|-------------------------|--------------------------|

Previous Warnings:

Date: _____
 V/W _____

Date: _____
 V/W _____

I have read this "warning decision" and understand it.

| | |
|--|-------------------------|
| Employee Signature <u>[Signature]</u> | Date <u>12/16/08</u> |
| Supervisor's Signature <u>[Signature]</u> | Date <u>12/16/08</u> |

Follow-Up Date: _____

FROM : AUTO CHLOR

FAX NO. : 5162930243

Dec. 11 2006 09:42AM P1



Corrective Action Form

| | |
|--------------------------------------|------------------------|
| Employee Name: <u>Richard Kealey</u> | Date of Warning: _____ |
| Branch <u>630</u> | |

| | | |
|---|-----------------------|--------------|
| Type of Violation (circle) Attendance Safety Dishonesty/Theft Carelessness Tardiness Insubordination Work Quality Drug/Alcohol | | |
| Violation Date: <u>7/18/08</u> | Violation Time: _____ | Place: _____ |

Company Statement:
 Richard did not inform me that he wanted 7/18/08 off as a personal day. He states that he spoke w/ the Ops mgr. who states he told Richie to get the OK from me. Richie never spoke to me - Richie then committed to coming in on Sunday to work in the shop. Work was not done.

Employee Statement:
☐ I agree with Statement
☐ I disagree with Statement for the following reasons:

Employee Signature: _____
 Date: _____

Warning Decision
 Richie will be suspended for two days w/o pay. If Richie's performance issues continue it will lead to termination.
 Approved by: Samuel Villanueva Title: Branch Mgr Date: _____

| |
|-----------------------------------|
| Previous Warnings: |
| Date: <u>9/17/07</u> V/W _____ |
| Date: _____ V/W _____ |

| | |
|--|---------------------|
| I have read this "warning decision" and understand it. | |
| Employee Signature _____ | Date <u>7/12/08</u> |
| Supervisor's Signature _____ | Date _____ |

Follow-Up Date: _____

EMPLOYEE FACT FINDING SHEET

6/24/11 - Driver called on route about MR Tong (cust # 956) having a leak for over a month. I recalled I dispatched that call to Richie over a month ago. When I asked Richie about replacing the part, he said he did get the call but he patched the hole & didn't replace the part. When I asked him why he did not give an answer.

6.29.11 - Richie did not go to a service call that he was given on 6.28.11 (Best Pizza). Customer called upset on 6.29.11 saying he called & no one has responded. When I asked Richie what happened, he said he was double parked but he left for another call.

10/6/11 Richie was given two calls on 10/3/11 or 10/4/11. On 10/5/11 Richie called out sick he has not returned to work since. On 10/11/11 both customers called upset & complaining that the tech was supposed to return w/ parts. Richie never notified me, even though he has called & spoken to me on several occasions.

EMPLOYEE FACT FINDING SHEET

5.25.11 We continue to have to go back to accounts that Richie had just recently performed service on. He also continues to miss diagnose service calls add additional cost & waste of time. Richie is back to forgetting to report issues that may be outstanding at accounts with service calls. (eg: signature, Branded) (La Nortena)

5.25.11 Brass Store called saying they placed a service call on 5.23.11 & no one has come to service the acct. Richie stated that he went & it was a 2 man job. I asked Richie what time he went he stated 11 AM & he was Double parked & he didn't see anyone. Customer said he was laying & he never went.

6.8.11 Richie was in a 2nd accident yesterday in 4 days. Bottle seems to have been available. Richie called me saying he side swiped someone on the BQE on Friday 6.3.11. The person didn't want to wait for Police Report so they settled on \$150 paid out by Richie. Yesterday Richie was hit by a car coming out of the parking lot.

EMPLOYEE FACT FINDING SHEET

On 4.26.11 Richie was given a service call around 4 PM for machine tripping Breaker at Linen in Bk. He called me around 9³⁰ pm saying he had been at the stop since 4 pm and couldn't repair the machine. I attempted to troubleshoot over the phone but it was too difficult. I arrived the Linen around 10³⁰ and noticed a burnt wire on the on/off switch. I repaired the wire & replaced the timer that Richie ^{had just} replaced because it did not work. The machine was repaired in 15 min. I believe Richie can not see well.

S.9.11 The utility van that Richie is allowed to take home was towed for 4 unpaid tickets - 2 were red lights, 1 was no night parking & one meter. I ask him where it was towed from he originally stated from the lot where it's kept overnight. When I asked him again from the marshal's office he said he left it outside the lot overnight & it was towed.

EMPLOYEE FACT FINDING SHEET

1.28.10 Richie called me @ 6^{am} asking to give him a day off for a funeral in CT for his kids. I told him that I couldn't give him the day off, that we have too many jobs scheduled today as well as he has had several lost days recently, he continued to ask ~~him~~ me to do him a favor. I declined.

1.29.10 Richie did not show up to work yesterday the 28th After I did not approve a day off.

9.22.10 Richie was told by Mike Buguade to change the surge meter @ Dallas BBQ but Richie did not. We had to send him again the next day.

9.23.10 I sent Richie to Sandoz on Friday 9.17.10 to check the dispenser for laundry. he went & found the acct closed. He did not notify me. I found out on 9.22.10 from the Sales person that the call was not done.

EMPLOYEE FACT FINDING SHEET

11.25.08 Richie was given a service call to see Sandra he went to a different account. Richie was given the RTR by Basht, & he left it at the office. He told no one until the next day.

11.24.09 Richie is continuing his lack of communication. Last week I gave him an RTR to go to Totares after 4pm to pick up money or shut off when he went he said acct was closed I asked him to return to shop & post the RTR on the board for the oncall tech to go later at night. The next day the tech did not go because ~~the~~ Richie did not post the RTR or call the tech to give him the info.

1.14.00 Richie had an operation on his eye on 1/12/00 which he had an excused absence. He said he would be into work on the 1/13/00, but he did not come in, instead he had his wife call in to say he was not coming in on both the 13th & again on the 14th. Rich returned to work on the 15th.

EMPLOYEE FACT FINDING SHEET

7/21/08 on Friday 7/18 - Richie did not show up to work & did not call. I asked Sergio if he knew why Richie was not at work and he stated that Richie asked him for that day off, but Sergio instructed him to talk to me. To request the day off, he never did.

11.18.08 Richie's Performance is slowing Down. He now needs half a day to perform service calls that should take an hour or two. He takes all day to rebuild 1 single machine that needs minimal work. He continues to fail to notify the office & myself when he is given a task & fails to complete it.

11.21.08 Richie was sent to Bristol's of Lyndbrook on two separate occasions in the last 3 weeks. One time for the Rinse & the other because the glasses were still spotty so he was to titrate & adjust mps accordingly. He reported all was well. Mike & I went 11.20.08 & found the Rinse was not pumping & there wasn't enough mps going in, also that there was a large amount of Calcium Build up due to hard water & that was causing a large amount of the spotting.

00:20 650-949-4185

AUTO CHLOR SYS CORP

PAGE 02

SERVICE REVIEW
THE FOUNDATION OF OUR COMPANY

| Steps to High Quality Service | Comments |
|---|---|
| Vehicle loaded properly, safe driving, parking. | <i>Drives safely. Truck organized.</i> |
| Enter account with route history, tools, parts, chemicals and a great attitude. Learn everyone's name. Briefly greet the owner, manager or key personnel. | <i>Appears to have friendly relationship with most customers. Usually brings tools into place.</i> |
| Inspect dishes, glasses, cups and tableware. | <i>Sometimes, should review results more often and in front of customer.</i> |
| Inspect equipment and make necessary adjustments and repairs. Check doors and operating system, drain solenoid, plunger and chain, round screen, spray nozzles, end caps, bearings, tray rail, chemical pumps, straws and tubing, water supply line, motor vents, wash, drain, flush, fill and rinse timing, timer box, wall charts, "nsf" and "property of" stickers. Run a load and check results. Capture chemicals. Check fill level. | <i>Carrying out a preventive maintenance program. Needs to measure chemical levels, run sacks and check results.</i> |
| Thoroughly clean (inside & out) of the machine. Polish outside of machine. | <i>Machines are clean & maintained.</i> |
| Inventory products and restock to par levels. Check for chemical overusage. | <i>OK</i> |
| Look for new sales opportunities. | <i>Needs to look for and ask for hard sales</i> |
| Prepare the sales and or service invoice. Do not list when sales opportunities exist. | <i>OK</i> |
| Document all service performed on the service report. | <i>OK</i> |
| Merchandise all services performed with the owner/manager. Bring the customer to the machine, review procedures, explain service performed. Promote additional products. | <i>Needs to make owner and manager aware of all the good service he is doing for them. Already does some of this</i> |
| Complete sales invoice (adding additional products.) | <i>OK</i> |
| Collect money or follow approved credit procedures. | <i>Collected money in professional manner</i> |
| Shake the customer's hand and tell them how much you appreciate their business. | <i>Remember to thank them for their business - make it personal, it is how you make your living.</i> |
| General Comments: | <i>Improved overall since my last route along. Interacts much more with customers and is giving better service. Needs to work on reviewing results and developing hard sales.</i> |

Note: Compare service to "Steps to Successful Service" found on pages 21-32 of the Operating Plan.

Route person: Richard Keating Period: ____ Day: ____ Date: 8/22/02

Management: E Ivy

Copy to:

Route person ____

Route Supervisor ____

Branch Mgr. ____

Regional Mgr. ____

Regional VP ____

President ____

Corporate Personnel File ____



Employee Performance Development Review 2007

Employee Name: Richard Keating

Date: 9/17/2007

Position: Rebuilder/ Service Tech

Date of Hire: 9/24/2001

Manager: Samuel Villanueva

Branch: 630

Appraisal Factors:

Please rate all employees using the following rating scale. Top value: 120 points.
Ratings should be done on the decimal system

5=Outstanding

4=Superior

3=Satisfactory

2=Needs Improvement

1=Unacceptable

Superior
performance
obvious to all.

Frequently
exceeds
standards.

Meets expectations.
Occasionally meets
or fails goals.

Meets some but
not all standards.
Improvement is
required.

Does not meet
standards.
Improvement is
needed.

Knowledge of Job:

4

Rich is by far the most capable of my team.

Product/Equipment Knowledge

4

Rich is very familiar with all ACS equipment and is a resource for his peers.

Quantity of Work

3

Rich continues to be a very supportive member of the branch. He will do whatever is asked to get the job done.

Quality of Work

2

Rich has had issues with quality and appearance of rebuilt machines. Rich plays a vital role as the rebuilder, the equipment he works on will be the first experience new customers will have with ACS equipment.

Time Management/Planning

3

Rich is productive with the time allotted.

Safety: Were all safety guidelines followed? Employee make any suggestions in regards to safety? Review DMV

3

Rich follows all safety regulations.

Attitude:

3

Rich has a positive attitude and is not resistant to change

Persistence:

3

Rich may have a tendency to give up before exhausting all options on installs.

Attendance:

2

Days Absent: 10

Late:

Rich has been absent from work to frequently for his key role, the absences seem to fall on Mondays or Fridays. Rich fails to notify his supervisor personally when he will not be at work he continues to relay messages thru others.

Judgment:

3

Rich is probably the most experience tech and makes decisions accordingly.

Initiative:

3

Rich frequently helps his peers and myself without being asked and often takes on tasks that have not been assigned to him.

Cleanliness/Organization/Housekeeping:

2

Rich needs to improve on the cleanliness and appearance of his vans and the equipment he rebuilds.

Cooperation/Teamwork:

4

Rich is frequently the resource for his peers and the branch.

Customer Service:

3

Rich has the customer's interest in mind during service calls performed.

Customer Relations:

3

Rich has good relationships with ACS customers.

Appearance:

3

Rich wears safety shoes and ACS uniforms at all times.

Install Planning Coordination:

3

A/R Management:

2

The Branch A/R to charge is 153% vs the company avg 111%. Everyone must do their part to help drive this measure down.

Collection:

2
The Branch A/R over 30 days is 48% vs the company avg 36%. Everyone must improve on the collection of their routes, ASAP.

Follow Through:

2
Rich frequently forgets to notify me of tasks assigned to him, but not completed. He also commits to weekend work and does not report to work.

Administration Work:

3
Rich must complete all paperwork correctly for processing in a timely manner.

Sales Results:

N/A

Sales Effort:

N/A

Cost Control:

3
Rich is very mindful of the branch's costs in regards to part and tool needs. Rich needs to min. the amount of unused parts stored in his van.

Total Points Earned: 63
(Maximum Amount Possible: 120)

Performance Summary:

Rich is a great ACS employee with a wealth of knowledge that he utilizes to support the Branch.

Goals for Next Performance Review:

Rich must improve on his attendance (reduce absences, notify supervisor directly), he must improve on his ability to follow through & his reliability, and along with everyone in the Branch, Rich must help drive the A/R # down through persistent collections.

Employee Comments:

I will try to improve whatever it takes to get the job done

Acknowledgements:

| | |
|-------------------------------|----------------------|
| Employee: <u>Richard Kent</u> | Date: <u>10/8/07</u> |
| Manager: <u>[Signature]</u> | Date: <u>10/8/07</u> |
| Human Resources: _____ | Date: _____ |

09/25/2001 08:10

7182915916

AUTOCHLOR

PAGE 01

Auto-Chlor
SYSTEM

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: Ed Ivy

BRANCH: 630

DATE: 9/25/01

RE: PAY INCREASE

EMPLOYEE: Richard Keating

CURRENT SALARY: _____

INCREASE: _____ PER PERIOD

OCT 05 2001

SALARY AFTER INCREASE: _____

EFFECTIVE DATE: Begins on Auto-Chlor payroll on 9/24/01

OTHER SALARY CHANGES: Salary is flat 2600⁰⁰ per 4 week
period.

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

01/11/2002 11:32 201-440-3856
FROM

AUTO CHLOR

PAGE 01
P. 1

Auto-Chlor
SYSTEM

Commercial Disinfecting & Laundry Service

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: Ed Ivy

BRANCH: 630

DATE: 1/11/02

RE: PAY INCREASE

EMPLOYEE: Richard Keating

CURRENT SALARY: _____

INCREASE: _____ PER PERIOD

SALARY AFTER INCREASE:

BASE 1520⁰⁰

9.50
per 4 week period

EFFECTIVE DATE:

12/13/01

JAN 11 2002

OTHER SALARY CHANGES: _____

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

01/28/2002 14:21

201-440-3856

AUTO CHLOR

PAGE 02

Auto-Chlor

SYSTEM

Commercial Cleaning & Laundry Service

ATTN:

CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM:

Ed Ivy

BRANCH:

630

DATE:

1/28/02

RE:

PAY INCREASE

EMPLOYEE:

JAN 28 2002

CURRENT SALARY:

5,50 Seen Chong

Base per
4 week pay
880.00

INCREASE:

PER PERIOD

4,8750 John Colosimo

780.00

SALARY AFTER INCREASE:

10,4088 Richard Keating

1675.00

EFFECTIVE DATE:

1/14/02

OTHER SALARY CHANGES:

SALARY A

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

07/26/2002 20:32 7182915916

AUTOCHLOR

PAGE 01
P. 1**Auto-Chlor**
SYSTEMATTN: CORPORATE OFFICE
PAYROLL DEPARTMENTFROM: Ed IvyBRANCH: 630DATE: 7/29/02

RE: PAY INCREASE

EMPLOYEE: Richard KeatingCURRENT SALARY: Base 1525 per period (4 weeks) 1675.01
Now getsINCREASE: (-150) PER PERIODSALARY AFTER INCREASE: 1525.01 per 9.5313EFFECTIVE DATE: 7/15/02 JUL 29 2002OTHER SALARY CHANGES:

_____ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE



ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM:

Tony Loonizilo C76

BRANCH:

C70

DATE:

11/07/02

RE:

PAY INCREASE

EMPLOYEE:

RICHARD KEATING

CURRENT SALARY:

INCREASE:

PER PERIOD

NOV 14 2002

SALARY AFTER INCREASE:

37,000 /YR YEAR FEAT

17,7885

EFFECTIVE DATE:

11/04/02

OTHER SALARY CHANGES:

OPS MGR

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

119 First Street, Suite 2001, Los Altos, CA 94022 • (408) 948-8888 • FAX (408) 948-4185

01/02/2004 22:38 7182915915

AUTOCHLOR

PAGE 01

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: 630 Tony LOUREL

BRANCH: 630

DATE: 1/5/04

RE: PAY INCREASE

EMPLOYEE: RICHARD KEATING

CURRENT SALARY: 37,000

INCREASE: 3% 8535 PER PERIOD

JAN 09 2004

SALARY AFTER INCREASE:

38,110.00 (2931.54) per period

EFFECTIVE DATE:

1/1/04 10/29/03

18,322.1

OTHER SALARY CHANGES:

Plus Manager Bonus

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: Tony Loureiro

BRANCH: 630

DATE: 12/30/2004

RE: PAY CHANGE

EMPLOYEE: RICHIE KEATING

CURRENT SALARY: 38,110 + BONUS

CHANGE: 2100 PER PERIOD

SALARY AFTER CHANGE: _____

EFFECTIVE DATE: 02-Jan-05

OTHER SALARY CHANGES: BASE of \$2100 Plus

4% ON ASH WASH & CHEMICAL & 12% ON HAND

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE


12/31/04

I corrected pay -
but we need to
deduct his
overpayment from
next check
496.54

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: Tony Loureiro

BRANCH: 630

DATE: 12/30/04

RE: PAY CHANGE

EMPLOYEE: Richard Keating

CURRENT SALARY: 38110+ bonus

CHANGE: 2100 PER PERIOD

SALARY AFTER CHANGE: _____

EFFECTIVE DATE: 02-Jan-05 12/27/04

OTHER SALARY CHANGES: base of 2100.00 Plus 4% dishwasher and Chemical

12% on hand

13.125

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

DEC 30 2004

s/d 2100 x 13.125 = 27562.50

2100 x 4% = 84.00

38,110.0000
2,100.0000
40,210.0000
40,210.0000
40,210.0000
2,080.0000
19,5313

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: TONY LOUREIRO

BRANCH: 630

DATE: 2/10/2006

RE: PAY CHANGE

EMPLOYEE: Richard Keating

CURRENT SALARY: _____

CHANGE: 11.1250 per hour

SALARY AFTER CHANGE: 1780.00 salary per period + commission

EFFECTIVE DATE: 2006

OTHER SALARY CHANGES: _____

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

ATTN: CORPORATE OFFICE
PAYROLL DEPARTMENT

FROM: mike bugiada

BRANCH: 630

DATE: 12/4/2006

RE:

EMPLOYEE: RICHARD KEATING

CURRENT SALARY: 23140 ANNUAL BASE

CHANGE: HOURLY OF 17.00

SALARY AFTER CHANGE: HOURLY @ 17.00 PER HOUR

ENTERED
DEC 27 2006

EFFECTIVE DATE: 12/4/2006 ✓

OTHER SALARY CHANGES: KEY TO INSTALLER ✓

ORIGINAL TO CORPORATE OFFICE
COPY FOR BRANCH FILE

Lincoln Financial Group

Page 1 of 1

Claim Detail

Group Protection
Online Services

Print Close

Payment Details

Submit Return-to-Work

Group ID: ACHLORSYS

Company Name

The Lincoln National Life Insurance Company

Member Information

Claimant Name

KEATING, RICHARD

SSN

117-64-8964

Address

466 Rockaway Parkway
APT 5D
BROOKLYN, NY 11212

Claim: 1110749398

Benefit
Type

Long Term Disability

Date of
Disability

10/05/2011

Date
Received

12/23/2011

Status

Pending

Closed
Date

Payment Information

Next Review Date

02/25/2012

Last Payment Date

01/27/2012

Payment Amount

\$1,175.85

Return To Work Information

Return-To-Work Part Time

N/A

Return-To-Work Full Time

N/A

Claim data is provided as of 1/30/2012 and subject to normal business processing. If you have questions, please contact our Employee Care Center at:

1-877-843-3948 - Disability & Life Claims

1-800-842-3729 - Dental Claims

BPClaims@LFG.com

Lincoln Financial Group is the marketing name for Lincoln National Corp. and its affiliates.

©2007 Lincoln National Corporation. All rights reserved. P102

12/28/2011 11:53 FAX 134/5290/66

UNLEDBUSINESS-SYS

00000000



New York State Insurance Fund Disability Benefits Claims

15 Computer Drive West Albany, New York 12205 Fax 518.437.5201

Richard Keating
Apt D5
466 Rockaway Pkwy
Brooklyn, NY 11203

November 14, 2011

Claimant: Richard Keating
SS Number: xxx-xx-8964

Case Number: 4d748634
Disability Date: 10/10/11
Case Manager: Jacqui L. unit 4
Telephone: 618-437-4303

CLAIMANT STATEMENT:

1. Have you recovered from your disability: Yes or No If yes, enter the date of recovery / /
CIRCLE ONE MO / DAY / YR
2. Have you worked since your disability: Yes or No If yes, enter the return-to-work date / /
CIRCLE ONE MO / DAY / YR

I, Richard Keating certify that the above statements are true and authorize my Physician to give to the New York State Insurance Fund all the information necessary to complete this form.

CLAIMANT SIGNATURE

DATE

PHYSICIAN STATEMENT: (cannot accept if a Physician Assistant or Nurse Practitioner completes this form)

- ☒ 1. Date of current treatment: 12/7/2011 DIABETIC RETINOPATHY
MO / DAY / YR
- ☐ 2. Present diagnosis and/or complications: DETACHED RETINA
- ☐ 3. If claim is for pregnancy, indicate date of delivery: / / type NATURAL or C-SECTION
Delivery date: ESTIMATED or ACTUAL CIRCLE ONE MO / DAY / YR
- ☐ 4. Date of OPERATION or BIOPSY: 10/14/11
MO / DAY / YR
- ☐ 5. DATE CLAIMANT MAY RETURN TO WORK: Undetermined
MO / DAY / YR

IMPORTANT: Even if considerable question exists, it is mandatory to make a reasonable "estimate" as to the date you believe this claimant will be able to perform their usual work. If terms like: "indefinite", "undetermined" or "unknown" are used, the processing of this claim will be delayed pending the receipt of a defined date. It is understood that the date indicated by the PHYSICIAN may be modified upon RE-EVALUATION.

- ☐ 6. DATE OF NEXT SCHEDULED APPOINTMENT (RE-EVALUATION): 2/1/12
MO / DAY / YR

PHYSICIAN SIGNATURE

DATE

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

METROPOLITAN RETINA ASSOCIATES, P.C.

KENNETH S. FELDER, M.D.

2035 RALPH AVENUE

BROOKLYN, NY 11234-0571

PHYSICIAN LICENSE NUMBER or STAMP

For the claimant to qualify for continued disability benefits, the Physician must complete all entries on this form and mail to: NYSIF Disability Claims, 15 Computer Drive West, Albany, NY 12205 or fax to: 518.437.5201.

12/28/2011 11:53 FAX 13475290766

UNITEDBUSINESS-SVS

002/005

201-438-3190

**Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)**

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections, 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request, 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form, 29 C.F.R. § 825.305(b).

Your name: Richard I Keating
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: KENNETH BENDER MD

Type of practice / Medical specialty: ORTHOPEDIC SURGERY

Telephone: (703) 209-0101 Fax: (703) 209-0194

12/28/2011 11:53 FAX 13475290766

UNIFIED BUSINESS SVCS

003/003

PART A: MEDICAL FACTS1. Approximate date condition commenced: 20+ yearsProbable duration of condition: 6 months

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☒ No ☐ Yes. If so, dates of admission: _____Date(s) you treated the patient for condition: 10/14/11 - NY Eye InfirmaryWill the patient need to have treatment visits at least twice per year due to the condition? ☒ No ☐ Yes.Was medication, other than over-the-counter medication, prescribed? ☒ No ☐ Yes.Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☒ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment: _____2. Is the medical condition pregnancy? ☒ No ☐ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ No ☒ Yes.

If so, identify the job functions the employee is unable to perform:

Patient cannot see.

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

legally blind due toD, which is not curable

12/28/2011 11:53 FAX 13475290768

UNITEDBUSINESS-SVS

004/005

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☒ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: Undetermined

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☒ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
☐ No ☒ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Undetermined

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☒ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
☐ No ☒ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

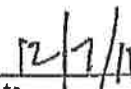
Legally Blind 20 to

D. Abetic who is fully

12/28/2011 11:53 FAX 13475290766

UNITEDBUSINESS-SVS

000/000


Signature of Health Care Provider
Date**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

**WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY - MENANDS
ALBANY, N.Y. 12241**

SR:ED 4WKS

To:

CARRIER OR
SELF-INSURED
EMPLOYER

THE STATE INSURANCE FUND
225 OAK ST
BUFFALO NY 14203

DATE OF THIS NOTICE

06/14/10

POLICY NO.

2295203

EFF. DATE

5/13/1988

Re:

CLAIMANT

RICHARD KEATING
300 E 38TH STREET APT 1F
BROOKLYN NY 11203

TYPE OF DISABILITY BENEFITS CLAIM

Disability began during employment

Disability began during first four weeks
following termination of employment

Disability began during extended post-
employment period covered as provided
in accepted plan.

EMPLOYER

AUTO-CHLOR SYSTEM OF
NEW YORK CITY INC
DBA AUTO-CHLOR SYSTEM
450 FERGUSON DR
MOUNTAIN VIEW CA 94043-5214

| | | | |
|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|
| LAST DAY WORKED 2/19/10 ER | FIRST DAY OF DISABILITY 2/20/2010 | DATE CLAIM FILED 4/13/2010 | CLAIMANT'S S.S. NO. XXX-XX-8964 |
|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|

TO INSURANCE CARRIER OR SELF-INSURED EMPLOYER:

Enclosed is a claim for Disability Benefits. You are required to process this claim immediately.
Reference: Disability Benefits Law Section 208, subd. 1, regarding prompt payment of benefits
and Section 220, subd. 4, regarding penalties for late payments of benefits.

IMPORTANT NOTICE TO CLAIMANT

We have forwarded your claim for disability benefits to your employer (if self-insured) or his/her insurance carrier, as indicated at the top of this notice. Please address any further inquiries to the above-named carrier or self-insured employer, who, according to the Disability Benefits Law, is responsible for the processing of your claim. If we can be of any further assistance please advise.

Disability Benefits
Claims Section

DB-315 (10-89)



MEMORANDUM

Date: April 1, 2010

To: Richard Keating

From: Alex Jewell, Director of Human Resources

Re: Leave of Absence- FMLA due to Medical reasons

In accordance with the policy set forth in the Auto-Chlor System Employee Handbook, you have requested a **FMLA Leave of Absence**. Attached is a copy of Auto-Chlor Systems leave policy. Please note the following conditions that exist during your Leave of Absence:

- You will go on FMLA starting 2/20/2010
- You are able to use accrued (Vac/Sick) (you need to notify Auto-Chlor System.)
- You will notify Auto-Chlor System if you need to use Vac./ Sick earlier.
- No employee benefits/seniority/holidays will accrue (Vac/Sick).
- Monthly cost of benefits: \$284.74 Due: 5/1 (Please note we pay for benefits a month ahead of time)
- Your medical coverage will switch to COBRA on 6/1/2010: \$973 is due
- Beginning date of Leave: 2/20/2010
- Return to work date: 5/24/2010
- Please return all the paperwork requiring your signature including leave forms and medical certification if required.
- Auto-Chlor System cannot guarantee a position will be open for you when you return from your FMLA Medical Leave of Absence if you exceed more then 12 weeks of consecutive leave (5/24/2010) or 12 weeks of intermittent leave within a 12-month period. Should you fail to contact Auto-Chlor System upon expiration of your leave we will assume you have resigned.
- We have also attached NY Disability Leave paperwork- please fill out and mail to NY State. ①
- Also attached is Auto-Chlor System's Long Term Disability Insurance. We advise you to fill it out ahead of the 90day-waiting period. ②
- Should you need an extension of your leave you need to contact us 3 days prior to expiration- 5/21/2010 with Dr's certification.
- Attached is a copy of Auto-Chlor System's Leave Policy
- You can call Paul Queen or Alex Jewell with any questions.

Please send the paperwork to : 450 Ferguson Dr. Mtn. View, Ca 94043

Fax: 650-960-3013

Attn: Paul Queen

Phone: 650-967-3085

I have read and understand the above regarding my FMLA Medical Leave of Absence.

Employee

Date

4/13/10



Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

June 10, 2010

AUTO-CHLOR SYSTEM
ATTN PAUL QUEEN
450 FERGUSON DR
MOUNTAIN VIEW CA 940435214

**The Lincoln National Life
Insurance Company**

Service Office:

PO Box 672408
Marietta, GA 30006-0041
toll free (800) 423-2765
www.LFG.com

Re: Policy Number: 00001001930900000
Claim Number: 1100016141
Claimant: RICHARD KEATING

Dear Paul Queen:

This letter is to inform you that the Long Term Disability claim filed by Mr. Keating has been approved beginning on 5/21/2010.

A detailed letter has been sent to Mr. Keating explaining how the benefits are administered. Due to the confidential nature of the approval documentation, we are unable to provide you with a copy of the actual letter sent.

Please notify us immediately should the employee return to work.

The LTD waiver of premium is effective on 6/1/2010.

Please contact our office with any questions you may have at the number listed above.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jondra Wise', written over a horizontal line.

Jondra Wise, DIA, DHP
Assoc. LTD Benefit Specialist

The Lincoln National Life Insurance Company

Long-Term Disability Claim Employee's Statement

To Be Completed By The Employee

A. Information about you

| | | | |
|--|---------------------|---|---|
| Last Name <u>KEATING</u> | | First <u>RICHARD</u> | Middle Initial <u>T</u> |
| Address <u>300 E 38 ST 1F1</u> | | City <u>BROOKLYN</u> | State/Province <u>NY</u> Zip <u>11203</u> |
| Telephone <u>(212) (646) 468-1541</u> | | Social Security Number <u>[REDACTED]</u> | |
| Date of Birth (Month, Day, Year) <u>03/04/64</u> | Height <u>5'11"</u> | Weight <u>209</u> | <input checked="" type="checkbox"/> Rt Handed <input type="checkbox"/> Lt. Handed |
| Your Employer (include division if applicable) <u>Auto-Chlor System Tech</u> | | <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |
| Occupation <u>Auto-Chlor System Tech</u> | | | |

B. Information about your family (required to determine your eligibility for Social Security benefits)

| | | | |
|---|--|--|---|
| Spouse's Name (Last, First) <u>Keating Elaine</u> | | Date of Birth (Month, Day, Year) <u>06-24-70</u> | Is your spouse employed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Spouse's Social Security Number <u>[REDACTED]</u> | | Date of Birth (Month, Day, Year) | |
| Children under age 25: Name (Last, First) <u>Mikhael Lovelace</u> | | <u>10-11-1984</u> | |
| <u>Martin Lovelace</u> | | <u>12-5-1990</u> | |
| <u>Margaret Lovelace</u> | | <u>10-3-1992</u> | |
| <u>Romario Stewart</u> | | <u>7-12-1994</u> | |

C. Information about the condition causing your disability

1. For pregnancy or illness, answer the following questions:

What were your first symptoms?

N/A

When did you first notice them?

Date you were first treated by a physician (Month, Day, Year)

02-21-2010

2. For an injury, answer the following questions:

Where and how did the injury occur?

During work

Date the injury occurred (Month, Day, Year)

02-16-2010

Date you were first treated by a physician (Month, Day, Year)

02-21-2010

3. For illness or injury, answer the following questions:

Why are you unable to work?

Surgery

Before you stopped working, did your condition require you to change your job or the way you did your job?

☐ Yes ☒ No If yes, explain

Is your condition related to your occupation?

☒ Yes ☐ No If yes, explainShoe caused injury which led to an infection

Have you filed, or do you intend to file a Workers' Compensation claim?

☐ Yes ☒ No

D. Information about the disability

Last day you worked before the disability

(Month, Day, Year) 02-19-2010

Did you work a full day?

☒ Yes ☐ No If no, explain

Date you were first unable to work?

(Month, Day, Year) 02-22-2010

Have you returned to work?

☐ Yes Part time (date) _____ Full time (date) _____☒ No

If you have not returned to work, do you expect to?

☒ Yes Part time (date) _____ Full time (date) N/A☐ No

Are you currently self-employed or working for another employer?

☐ Yes ☒ No If so, give details.

(Continued on next page)

E. Information about physicians and hospitals

First medical attention for the current disability was given by (complete below):

| | | |
|---|--|--|
| Doctor's Name <i>Tanna Gelter DPM</i> | Telephone: <i>718-377-1212</i> Fax: <i>718-258-1405</i> | Specialty <i>Podiatrist</i> |
| Address (Street, City, State, Zip) <i>5412 - Kiny Plaza Mall Bldg NY 11234</i> | | Dates Seen <i>2/21/10</i> To <i>current</i> |

List all other physicians and hospitals you have seen for this condition:

| | | |
|------------------------------------|--------------------|------------------|
| Doctor's Name | Telephone: Fax: | Specialty |
| Address (Street, City, State, Zip) | | Dates Seen To |
| Doctor's Name | Telephone: Fax: | Specialty |
| Address (Street, City, State, Zip) | | Dates Seen To |
| Doctor's Name | Telephone: Fax: | Specialty |
| Address (Street, City, State, Zip) | | Dates Seen To |

| | |
|---|--|
| Hospital <i>Peninsula Hospital</i> | Dates of Confinement <i>2/21/10</i> To <i>3/07/10</i> |
| Address (Street, City, State, Zip) <i>5115 Beach Channel Dr. Far Rockaway NY 11691</i> | |

Have you ever had the same or a similar condition in the past?

☐ Yes ☒ No If yes, complete the following concerning your past treatment:

| | | |
|------------------------------------|--------------------|----------------------------|
| Doctor's Name | Telephone: Fax: | Specialty |
| Address (Street, City, State, Zip) | | Dates Seen To |
| Hospital | | Dates of Confinement To |
| Address (Street, City, State, Zip) | | Dates of Confinement To |

F. Information about other disability income

(Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.)

| Source of Income | Amount | / (wk., mon.) | Date claim was filed | Date payments began | Date payments ended |
|---|--------|---------------|----------------------|---------------------|---------------------|
| Social Security Retirement | \$ | / | . | . | . |
| Social Security Disability/Yourself | \$ | / | . | . | . |
| Social Security Disability/Dependents | \$ | / | . | . | . |
| Canadian Pension Plan | \$ | / | . | . | . |
| Workers' Compensation | \$ | / | . | . | . |
| State Disability | \$ | / | . | . | . |
| Pension/Retirement | \$ | / | . | . | . |
| Pension/Disability | \$ | / | . | . | . |
| Short Term Disability | \$ | / | . | . | . |
| Unemployment | \$ | / | . | . | . |
| No-Fault Insurance | \$ | / | . | . | . |
| Railroad Retirement | \$ | / | . | . | . |
| Other (include individual or group benefits): | \$ | / | . | . | . |

G. Information about income tax withholding

If your request for benefits is approved, should The Lincoln National Life Insurance Company withhold income taxes from your benefit checks?

☐ Yes ☒ No If yes, how much should be withheld from each check. Federal taxes (minimum is \$88.00 per month) \$.00**H. Signature (Required for all claims)**

Under what other policies with The Lincoln National Life Insurance Company are you currently covered?

The above statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements.

x *[Signature]*
Signature of Employee

04-13-2010
Date

Long-Term Disability Claim Physician's Statement

This form should be completed by the physician who was treating the claimant when he or she last worked.

To Be Completed By The Attending Physician**A. General Information**

This claim is for (Patient's Name)

Richard Keating

| | | | | |
|----------------------------------|--------|--------|----------------|----------------------------------|
| Patient's Social Security Number | Height | Weight | Blood Pressure | Date of Birth (Month, Day, Year) |
| | | | | <i>03/04/64</i> |

Primary Diagnosis including ICD 9 or DSM code

*250.60 707.15 785.4 681.10***B. Complete this section for normal pregnancy, then go to section E.**

What was the date of the last menstrual period?

What is the expected date of delivery?

What is the expected length of postpartum recovery?

What was the first date of treatment?

What was the last date of treatment?

C. Complete this section for all conditions except normal pregnancy.

Symptoms

Swelling, ulcerations Diabetes with neuropathy

Objective Findings

Are there secondary conditions contributing to the disability?

☒ Yes ☐ No If yes, what are they? (Please include ICD 9 or DSM code.)*Diabetes*If this is a cardiac condition, what is the functional capacity?
(American Heart Association)☐ Class 1 - No limitation☐ Class 3 - Marked limitation☐ Class 2 - Slight limitation☐ Class 4 - Complete limitation

When did symptoms first appear?

*02/07/10*Date of the patient's first visit
(Month, Day, Year)*02/01/10*Date you believe the patient was first unable to work
(Month, Day, Year)*2/20/10*Date of the patient's last visit
(Month, Day, Year)*04/05/10*

How often do you see the patient?

Weekly

Is the patient's condition work related?

☐ Yes ☒ No If yes, explain:

Has the patient undergone surgery?

☒ Yes ☐ No If yes, give date, procedure and result.

If no, do you expect surgery to be performed in the future?

☐ Yes ☐ No If yes, give date and type of surgery.

What medication is the patient currently taking?

As per PCP

Please indicate other types and frequencies of treatment.

Wound Redressing

Has the patient been referred to a medical rehabilitation or therapy program?

☒ Yes ☐ No If yes, give details.*Home care Services*

Have you referred the patient for other types of consultations?

☐ Yes ☒ No If yes, give details.

Has the patient been hospital confined?

☒ Yes ☐ No If yes, complete the following:

Name of Hospital

Peninsula Hospital

Address

5115 Beach Channel Drive Far Rockaway NY 11691

Dates of Confinement

2/21 through 3/07/10

(Continued on next page)

D. Information about the patient's inability to work

Briefly describe restrictions and limitations.

Restrictions (What the patient SHOULD NOT do)

limited ambulation

Limitations (What the patient CANNOT do)

stand or walk for any period of time - unable to wear regular shoe

What is your prognosis for recovery?

good with proposed treatment

Has patient achieved maximum medical improvement?

☐ Yes ☒ No If no, complete the following:

How soon do you expect fundamental changes in the patient's medical condition?

☐ 1 - 2 months☐ 5 - 6 months☒ 3 - 4 months☐ more than 6 months

Give details concerning expected improvement or deterioration:

In an eight hour workday, claimant can: (Circle full hourly capacity for each activity)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|-------|---|---|---|---|---|---|---|---|
| Sit | | | | | | | | |
| Stand | | | | | | | | |
| Walk | | | | | | | | |

Are there restrictions in:

Yes No

Comments

Lifting/Carrying

☐☐

Use of hands in repetitive actions

☐☐

Use of feet in repetitive movements

☐☐

Bending

☐☐

Squatting

☐☐

Crawling

☐☐

Climbing

☐☐

Reaching above shoulder level

☐☐

Other (please specify)

☐☐*When Patient returns to work he will have no limitations.*

When do you expect claimant to return to prior level of functioning?

about 5/31/13

Would you recommend vocational rehabilitation for this patient?

☐ Yes ☐ No**E. Required Attachments and Signature**

After you have fully completed this form, attach copies of the following materials:

- Office notes for the period of treatment for the last two years
- Test results showing objective findings
- Hospital discharge summaries
- Consulting physician reports

Your Name

Janna Gelter

Degree

DPM

Specialty

Podiatrist

Telephone: (718) 377-1212

Fax: (718) 258-1405

Address

5412 - Korp Plaza Mall. Bklyn NY 11237

X

Signature of Attending Physician (no stamp)

Date

4/21/13

incul back to Auto-Labor

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



(When completed, this form goes to the employee, Not to the Department of Labor.)

OMB No.: 1215-0181
Expires: 09-30-2010

1. Employee's Name

Keating, Richard

2. Patient's Name (If different from employee)

Keating, Richard

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____, or None of the above _____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Diabetic - Deep ulcer/Abcess left foot

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity² if different):

02/20/10

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

NO

If yes, give the probable duration:

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently Incapacitated² and the likely duration and frequency of episodes of incapacity²:

Weekly Redressings

Yes

¹ Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

² "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.



MEMORANDUM

Date: April 1, 2010

To: Richard Keating

From: Alex Jewell, Director of Human Resources

Re: Leave of Absence- FMLA due to Medical reasons

In accordance with the policy set forth in the Auto-Chlor System Employee Handbook, you have requested a FMLA Leave of Absence. Attached is a copy of Auto-Chlor Systems leave policy. Please note the following conditions that exist during your Leave of Absence:

- You will go on FMLA starting 2/20/2010
- You are able to use accrued (Vac/Sick) (*you need to notify Auto-Chlor System.*)
- *You will notify Auto-Chlor System if you need to use Vac./ Sick earlier.*
- No employee benefits/seniority/holidays will accrue (Vac/Sick).
- Monthly cost of benefits: \$284.74 Due: 5/1 (Please note we pay for benefits a month ahead of time)
- Your medical coverage will switch to COBRA on 6/1/2010: \$973 is due
- Beginning date of Leave: 2/20/2010
- Return to work date: 5/24/2010
- Please return all the paperwork requiring your signature including leave forms and medical certification if required.
- Auto-Chlor System cannot guarantee a position will be open for you when you return from your FMLA Medical Leave of Absence if you exceed more then 12 weeks of consecutive leave (5/24/2010) or 12 weeks of intermittent leave within a 12-month period. Should you fail to contact Auto-Chlor System upon expiration of your leave we will assume you have resigned.
- We have also attached NY Disability Leave paperwork- please fill out and mail to NY State. ①
- Also attached is Auto-Chlor System's Long Term Disability Insurance. We advise you to fill it out ahead of the 90day-waiting period. ②
- Should you need an extension of your leave you need to contact us 3 days prior to expiration- 5/21/2010 with Dr's certification.
- Attached is a copy of Auto-Chlor System's Leave Policy
- You can call Paul Queen or Alex Jewell with any questions.

Please send the paperwork to : 450 Ferguson Dr. Mtn. View, Ca 94043

Fax: 650-960-3013

Attn: Paul Queen

Phone:650-967-3085

I have read and understand the above regarding my FMLA Medical Leave of Absence.

Employee

Date

4/13/10